Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ARLINGTON ORTHOPEDIC ASSOCIATES
800 ORTHOPEDIC WAY
ARLINGTON TX 76015

Carrier's Austin Representative Box
Box Number 47

Respondent Name
GENERAL MOTORS CO

MDR Received Date
December 20, 2011

MFDR Tracking Number
M4-12-1213-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "The office visit denied as being inclusive to 20550 on same date of service. I sent in a reconsideration by correcting the diagnosis linkage and added a 25 modifier. I have sent the appeal twice. Sedgwick keeps denying it as a duplicate. They need to reprocess 99212-25 for payment."

Amount in Dispute: $57.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Requestor's documentation, the Claimant saw the doctor solely to receive an injection. Because of this, the office visit charge is not reimbursed separately. In conclusion, reimbursement is not owed for the office visit."

Response Submitted by: Downs-Stanford, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2011	CPT Code 99212-25	$57.34	$ 57.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the procedures for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 5, 2011, November 8, 2011 and November 28, 2011:
   - 48 – The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- QA – The amount adjusted is due to bundling or unbundling of services.
- 18 – Duprlicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Did the requestor file the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor bill the treatment/service in accordance with 28 Texas Administrative Code §134.203?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(1-2) the requestor has met the requirements of the rule.
2. Per 28 Texas Administrative Code §134.203(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.
3. Review of the submitted documentation and the correct coding initiatives for the CPT code set 99212 and 20550 shows these codes are not bundled; therefore, reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $57.34.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $57.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 31, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.